

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09700					09699				
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodbine</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Golden Age Guest Home -</i>					d. STREET ADDRESS <i>2715 Glendale Rd.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Jane Mary Alexander</i>					4. DATE OF DEATH <i>July 7 1966</i>		5. SEX <i>Female</i>		
6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 26, 1880</i>		9. AGE (in years, last birthday) <i>86</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>? Devine</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>133-03-9533</i>		17. INFORMANT <i>Mr. Edward F. Alexander</i>		Address (Same)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Cardio Vascular</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>?</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>April 12, 1966</i> to <i>July 7, 1966</i> , that (I) (we) last saw the deceased alive on <i>July 7, 1966</i> , and that death occurred at <i>8:55 P.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>M. N. Mastin</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>July 7 - 66</i>			
22c. PHYSICIAN'S NAME (Type) <i>M. N. MASTIN</i>				22d. ADDRESS <i>Westminster Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<i>Cremation</i>		<i>7/11/66.</i>		<i>Greenmount Crematory</i>		<i>Baltimore, Md.</i>			
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>				ADDRESS		25a. REC'D BY REGISTRAR <i>JUL 11 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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09701

CERTIFICATE OF DEATH

09700

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 3y. 1m. 17d.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Amanda (NMN) Anderson		4. DATE OF DEATH Month Day Year 7 15 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/77
9. AGE (In years) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 9 2	11. IF UNDER 24 HRS. Hours Min. 15 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rudolph Studhalter		14. MOTHER'S MAIDEN NAME Anna Hoehn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Springfield Hospital records, Sykesville		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration DUE TO (c) Hypertension INTERVAL BETWEEN ONSET AND DEATH days weeks years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Chronic brain syndrome with cerebral arteriosclerosis with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (*) (this hospital) attended the deceased from 5/28/1963 , to 7/15/1966 that (*) (we) last saw the deceased alive on 7/15/1966 , and that death occurred at 11:00 a.m. from causes and on the date stated above.			
22a. SIGNATURE Edmee J. Reeves		22b. DATE SIGNED 7/15/66	
22c. PHYSICIAN'S NAME (Type) Edmee J. Reeves, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial--transit 7-16-66		23b. DATE THEREOF 7-16-66	
23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		23d. LOCATION (City or Town) (County) (State) St. Louis, Missouri	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR JUL 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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U. S. DEPARTMENT OF AGRICULTURE

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
09702						09701					
1. PLACE OF DEATH a. COUNTY <i>Carroll</i>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Penna</i> b. COUNTY <i>York</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester, Md.</i>						c. LENGTH OF STAY IN ID <i>21 days.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Longview Nursing Home 128 W. Grand St. Manchester, Md.</i>						d. STREET ADDRESS <i>Honover, Pa RD #1 75-3</i>					
3. NAME OF DECEASED (Type or print) First Middle Last <i>Delilah Virginia Annenest</i>						4. DATE OF DEATH Month Day Year <i>July 1 1966</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 29, 1897</i>		9. AGE (In years last birthday) <i>68 yrs.</i>		10. FUNERAL 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>MD Carroll Co</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>John Bixler</i>						14. MOTHER'S MAIDEN NAME <i>Laura Glas.</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>210-32-5697</i>		17. INFORMANT (Daughter) Address <i>Mrs. Vontamahanna Hampstead, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Hypertension Cerebrovascular Disease</i> (b) DUE TO (c)										?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cholera Hemorrhage</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>July 10</i> , 19 <i>66</i> , to <i>July 1</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>July 1</i> , 19 <i>66</i> , and that death occurred at <i>12 P.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Sept E Bush</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>July 1, 1966</i>			
22c. PHYSICIAN'S NAME (Type) <i>Sept E Bush MD</i>						22d. ADDRESS <i>Hampstead, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/4/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Manchester Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Manchester Md.</i>					
24. FUNERAL DIRECTOR <i>Tipton-Eline</i>						ADDRESS <i>Hampstead, Md.</i>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			

50520

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09703

CERTIFICATE OF DEATH

09702

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN b 4y. 1m. 12d. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3417 Glenmore Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Wilhelmina Middle Bernadine Last Bachman		4. DATE OF DEATH Month 7 Day 4 Year 1966				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/73	9. AGE (In years last birthday) yrs. 92	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Bailey			14. MOTHER'S MAIDEN NAME Ulferas, Anna			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Delmar F. Bachman Springfield Hospital records-Sykesville		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 334X DUE TO (b) Dehydration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome with cerebral arteriosclerosis without qualifying phrase.						INTERVAL BETWEEN ONSET AND DEATH days days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from 5/23/ , 1962, to 7/4/ , 1966, that he (we) last saw the deceased alive on 7/4/ , 1966, and that death occurred at 9:30 M, from causes and on the date stated above.						
22a. SIGNATURE Naci N. Buyukunsal, M.D.				22b. DATE SIGNED 7/4/66		22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.
22d. ADDRESS Springfield State Hospital Sykesville, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/66		23c. NAME OF CEMETERY OR CREMATORY First United Evangelical Church Cem. Balto. Md		23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR HENRY SANDER & SONS & INC. BALTO. MD.				25a. REC'D BY REGISTRAR JUL 7 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge

1035

00580

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
09704					09703						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY CARROLL MARYLAND					a. STATE Maryland b. COUNTY Baltimore City						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore							
c. LENGTH OF STAY IN 1b 4mos. 1 day				d. STREET ADDRESS 3840 Dolfield Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital											
3. NAME OF DECEASED (Type or print)			First ANNA		Middle MAE		Last BAKER		4. DATE OF DEATH Month July Day 15 Year 19 66		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-8-97		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) South Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Murray						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-52-1164		17. INFORMANT Records Address Sykesville Springfield State Hospital Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO (b) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Generalized Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 48 hours years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-14-1966 , to 7-15-1966 , that (I) (we) last saw the deceased alive on 7-15-1966 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.											
22a. SIGNATURE <i>Ilse Kamm</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED July 15, 1966			
22c. PHYSICIAN'S NAME (Type) Ilse Kamm, M.D.						22d. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7-19-66		23c. NAME OF CEMETERY OR CREMATORY Arbutus Men. Park			23d. LOCATION (City, town or county) (State) Arbutus Md			
24. FUNERAL DIRECTOR Elroy O. Wilson						ADDRESS 1000 Brown Thicket Ave		25a. REC'D BY REGISTRAR JUL 25 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09705

CERTIFICATE OF DEATH

09704

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Westminster, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 Year</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		d. STREET ADDRESS <u>Route 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural-Westminster</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M.</u> Last <u>Barnes</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1893</u>
9. AGE (In years last birthday) yrs. <u>72</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ira R. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Eva Henry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Walter S. Barnes</u>		Address <u>Same as Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>7220</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HEMORRHOIDAL AG-EC, CHRONIC ULCERS</u> DUE TO (c) <u>RHEUMATOID ARTHRITIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>MARIE STRUMPELS ARTH., HCV D.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>66</u> to <u>7-2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-2</u> , 19 <u>66</u> , and that death occurred at <u>2:04</u> M., from causes on and on the date stated above.			
22a. SIGNATURE <u>R. V. Houck, Jr.</u>		22b. DATE SIGNED <u>7-2-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. V. Houck, Jr.</u>		22d. ADDRESS <u>Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/5/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Winfield Church Of God</u>		23d. LOCATION (City or Town) (County) (State) <u>Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz</u>		25a. REC'D BY REGISTRAR <u>Jul 6 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1544

10520

09706

CERTIFICATE OF DEATH

09705

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 19yrs.5mos.15days.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RUSSELL EASTMAN BEALL		4. DATE OF DEATH Month Day Year JULY 1 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-1892
9. AGE (In years last birthday) yrs. 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sprigg Beall		14. MOTHER'S MAIDEN NAME Sarah Sansbury	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-7585	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric artery thrombosis DUE TO (b) Coronary artery disease of heart DUE TO (c) Years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with convulsive disorder, with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-16-47 , 19__, to 7-1-66 , 19__, that (I) (we) last saw the deceased alive on 7-1-66 , 19__, and that death occurred at 6:15 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Octavio A. Ruiz</i>		22b. DATE SIGNED 7-1-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/3/66	
23c. NAME OF CEMETERY OR CREMATORY Cem. Forest Memorial Meth.		23d. LOCATION (City or Town) (County) (State) Forestville Md.	
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR DATE JUL 6 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08705

CERTIFICATE OF DEATH

08706

John Doe

John Doe

John Doe

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

08

John Doe

John Doe

John Doe

John Doe

08

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

08

John Doe

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

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John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

John Doe, born [illegible], [illegible]

09707

CERTIFICATE OF DEATH

09706

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Boring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		d. STREET ADDRESS 03-2	
3. NAME OF DECEASED (Type or print) First HATTIE Middle OSBORN Last BELT		4. DATE OF DEATH Month 7 Day 8 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/82
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwi.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John D. Osborn		14. MOTHER'S MAIDEN NAME Elizabeth Akehurst	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-38-2216	
17. INFORMANT Mr. L. Russell Osborn, Boring, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539 INTESTINAL OBSTRUCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF BOWEL DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 WKS. YMOS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/7 , 1966, to 7/8 , 1966, that (I) (we) last saw the deceased alive on 7/8 , 1966, and that death occurred at 11:45 M, from causes and on the date stated above.			
22a. SIGNATURE Wm. J. Knowlton Jr.		22b. DATE SIGNED 7/8/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/11/66	23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove	23d. LOCATION (City or Town) (County) (State) Balto. Co. Md.
24. FUNERAL DIRECTOR Tipton-Eline		25a. REC'D BY REGISTRAR DATE JUL 13 1966	
ADDRESS Hampstead, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES OF AMERICA

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09708

CERTIFICATE OF DEATH

09707

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middleburg, 21768</u>	
c. LENGTH OF STAY IN lb. <u>7 mos./1 da.</u>		d. STREET ADDRESS <u>06-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Gibson BOCKMILLER</u>		4. DATE OF DEATH Month Day Year <u>July 30, 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>11-23-93</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Organist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Played in Churches</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Robert Bockmiller - dec.</u>		14. MOTHER'S MAIDEN NAME <u>Clara ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-52-2952-T</u>	
17. INFORMANT <u>Springfield State Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain abscess cause undetermined</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inanition. Multiple decubitis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-29-65</u> , 19__, to <u>7-30-66</u> , 19__, that (I) (we) last saw the deceased alive on <u>7-30-66</u> , 19__, and that death occurred at <u>2 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Antonius Glahn, M.D.</u>		22b. DATE SIGNED <u>7-30-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Antonius Glahn, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital Sykesville, Maryland 21781</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/3/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Edson Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 4 1966</u>	
ADDRESS <u>Catonsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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09709

CERTIFICATE OF DEATH

09708

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1yr. 11mo 7 da d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30-4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HENRY BOWERSOX		4. DATE OF DEATH Month Day Year July 10 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-92/91
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Bowersox	
14. MOTHER'S MAIDEN NAME Elizabeth Shaffer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-18-5841		17. INFORMANT Records, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO Nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 8-17-64 , 19__, to July 10, 19 66 that (I) (we) last saw the deceased alive on 7-10-66 , 19__, and that death occurred at 6:15 AM , from causes and on the date stated above.	
22a. SIGNATURE Eduards R. Acle 22c. PHYSICIAN'S NAME (Type) Eduards R. Acle M.D.		22b. DATE SIGNED 7-1 -66 22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) 7-14-66		23b. DATE THEREOF 7-14-66	
23c. NAME OF CEMETERY OR CREMATORY Corraime PK.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Frank H. Seitz ADDRESS 814 W 36th St. BALTO.		25a. REC'D BY REGISTRAR JUL 13 1966 25b. REGISTRAR'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

09710

CERTIFICATE OF DEATH

09709

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>6 mos./5 das.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 20910</u>				15. 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>8912 Fairview Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>BARBARA</u> Last <u>BRANDT</u>				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1966</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9-18-1887</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>66</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Kratz -</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth KAMMER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Walter W. Brandt, 1415 Stateside Dr., S.S., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia.</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Diabetes Mellitus.</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome assoc. with cerebral arteriosclerosis.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>65</u> , to <u>7/3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 3</u> , 19 <u>66</u> , and that death occurred at <u>8:45 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>SP Wise</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 3, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Samuel P. Wise, III, M.D.</u>				22d. ADDRESS <u>Springfield State Hospital Sykesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 6, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>C. Glenn Carter, 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

0350

07520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
09711						09710					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
CARROLL			Rural - Sykesville			Maryland			CARROLL		
c. LENGTH OF STAY IN b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
30 years			Barthlow Road			Rural - Sykesville			Barthlow Rd.		
e. IS RESIDENCE ON A FARM?											
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First			Middle			Last		
William McKinley Brooks									4. DATE OF DEATH		
									Month		
									Day		
									Year		
									July 23 1966		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Col		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9-10-1898		67 yrs.		Months	
										Days	
										Hours	
										Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Chauffeur				Lumber				Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
Benjamin Brooks				Alice Hill				U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
No				219-05-0370				Mrs. Mary Green - Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver, severe											
5810 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malnutrition											
DUE TO (c) Anemia; cardiac failure with arrest.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
Hour a.m. p.m.				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20f. (City or town) (County) (State)			
19											
21. I certify that (I) (this hospital) attended the deceased from Jan. 1966, to July 23, 1966, that (I) (we) last saw the deceased alive on July 23, 1966, and that death occurred at 7:30 M, from the causes and on the date stated above.											
22a. SIGNATURE								22b. DATE SIGNED			
Howard E. Hall								M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		July 27, 1966	
22c. PHYSICIAN'S NAME (Type)								22d. ADDRESS			
Howard E. Hall, M.D.								Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial				7-27-66		St. Luke Cemetery			Sykesville, Md.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harry W. Haight Sykesville, Md.						JUL 29 1966		Charles Judge			

1931

THE STATE OF TEXAS

1931

1931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster RD #6</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll County General Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>BABY GIRL BUCHANAN</u>						4. DATE OF DEATH <u>JULY 6 1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 6 1966</u>		9. AGE (In years last birthday) <u>0</u> yrs. <u>0</u> months <u>0</u> days <u>40</u> hours <u>0</u> min.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Westminster, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Woodrow Buchanan</u>						14. MOTHER'S MAIDEN NAME <u>Judith Carr</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service) <u>—</u>						16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Woodrow Buchanan</u> Address <u>Westminster, Md. RD #6</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple Congenital Abnormalities</u> 7512 DUE TO <u>1) Intra uterine Hydrocephalus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2) perinatal myelomelia</u> DUE TO (c) <u>3) double cleft lip and palate</u> <u>Prematurity 12'10"</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Toxemia of pregnancy</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <u>1</u> (this hospital) attended the deceased from <u>7-6, 1966</u> , to <u>7-6, 1966</u> , that (if (we) last saw the deceased alive on <u>7-6-66</u> 19 <u>66</u> , and that death occurred at <u>5</u> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Karl W. Green</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7/6/66</u>											
22c. PHYSICIAN'S NAME (Type) <u>KARL W. GREEN M.D.</u> 22d. ADDRESS <u>WESTMINSTER, MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Carroll Westminster, Md.</u>			
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, Md.</u> ADDRESS <u>Westminster, Md.</u>						25a. REC'D BY REGISTRAR <u>JUL 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

6-201524

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09713

CERTIFICATE OF DEATH

09712

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Henryton c. LENGTH OF STAY IN b. 714 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Henryton State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air d. STREET ADDRESS Conowingo Road, Box 841 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mildred Frona Caudill		4. DATE OF DEATH July 25 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-24
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bert M. Caudill		14. MOTHER'S MAIDEN NAME Stella Hamm	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Stella Caudill - Same as patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) undetermined cause DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 10, 1964 to July 25, 1966 , that (I) (we) last saw the deceased alive on July 25, 1966 , and that death occurred at 9:10 a.m. , from the causes and on the date stated above.			
22a. SIGNATURE Edgars M. Maculans M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.		22b. DATE SIGNED July 25, 1966	
22d. ADDRESS Henryton, Maryland 21080			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 27, 1966	23c. NAME OF CEMETERY OR CREMATORY Welcome Home Baptist Church Cem	23d. LOCATION (City, town or county) (State) Bel Air, Harford Co., Maryland 21014
24. FUNERAL DIRECTOR'S SIGNATURE Foster Funeral Home ADDRESS W. Beardsley Bel Air Md		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE Charles Judge	

09719

09719

Barford

Barford

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Barford State Hospital

Barford State Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
09714 CERTIFICATE OF DEATH 09713											
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Detour						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Detour					
c. LENGTH OF STAY IN 1b Lifetime						d. STREET ADDRESS 06-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Reuben Middle Edward Last Clabaugh			4. DATE OF DEATH Month July Day 22 Year 19 66								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14, 1900		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 06 Days 10	
										IF UNDER 24 HRS. Hours 10 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Carroll CO. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Edward Clabaugh						14. MOTHER'S MAIDEN NAME Carrie Wilhide					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-36-6219		17. INFORMANT Mr. Charles Clabaugh, Detour, Maryland				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency											
INTERVAL BETWEEN ONSET AND DEATH 5 yrs 10 yrs											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1/13 19 62 to 7/22 , 19 66 , that (I) (two) last saw the deceased alive on 7/11 19 66 and that death occurred at 6 A.M. from the causes and on the date stated above.											
22a. SIGNATURE R.S. McVaugh M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/22/66			
22c. PHYSICIAN'S NAME (Type) R.S. McVaugh						22d. ADDRESS Taneytown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 24, 1966		23c. NAME OF CEMETERY OR CREMATORY Keysville Cemetery		23d. LOCATION (City, town or county) (State) Keysville, Carroll Co., Md.					
24. FUNERAL DIRECTOR'S SIGNATURE John R. Skiles ADDRESS C.O. Fuss & Son, Taneytown, Md.						25a. REC'D BY REGISTRAR JUL 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

09170

UNITED STATES OF AMERICA

09170

UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09715

CERTIFICATE OF DEATH

09714

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural) Sykesville		c. LENGTH OF STAY IN 1b Oy 11m 13d	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		20910 15-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1229 Noyes Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ralph Middle Guy Last Cornell		4. DATE OF DEATH Month 7 Day 19 Year 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5-20-91
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer --		10b. KIND OF BUSINESS OR INDUSTRY U. S. -- Govt.	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Cornell		14. MOTHER'S MAIDEN NAME unknown Augusta Engalls	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Army 1946 WW II		16. SOCIAL SECURITY NO. 220-34-8453	
17. INFORMANT Irene A. Cornell Address 1229 Noyes Drive Silver Spring, Md.		Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Arteriosclerotic vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with senile brain disease with psychotic reaction. Pneumonia.		INTERVAL BETWEEN ONSET AND DEATH 12 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --	
20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. -7		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State) --	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8-6 , 19 65 , to 7-19 , 19 66 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 7-19 , 19 66 , and that death occurred at 10:10 p.m. from causes and on the date stated above.			
22a. SIGNATURE Heinz H. Klaatsch		22b. DATE SIGNED 7-20-66	
22c. PHYSICIAN'S NAME (Type) Heinz H. Klaatsch, M.D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 22, 1966	
23c. NAME OF CEMETERY OR CREMATOR St. Lincoln Cemetery		23d. LOCATION (City or town) (County) (State) Prince Georges Co., Md.	
24. FUNERAL DIRECTOR John B. Thomas Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR DATE JUL 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

03713

TESTIMONY OF DEATH

03713

Name of deceased		John Doe	
Date of death		May 15, 1960	
Place of death		New York	
Cause of death		Heart failure	
Medical history		Hypertension, Diabetes	
Occupation		Teacher	
Family history		None	
Signature of physician		[Signature]	
Signature of witness		[Signature]	
Signature of next of kin		[Signature]	
Date of entry		May 16, 1960	
Place of entry		New York	
Signature of official		[Signature]	
Date of filing		May 17, 1960	
Place of filing		New York	
Signature of clerk		[Signature]	
Date of completion		May 18, 1960	
Place of completion		New York	
Signature of official		[Signature]	
Date of final review		May 19, 1960	
Place of final review		New York	
Signature of official		[Signature]	
Date of final filing		May 20, 1960	
Place of final filing		New York	
Signature of official		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09716

09715

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF TIME IN 1b <u>50 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>36 BOND ST</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>36 BOND ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																			
3. NAME OF DECEASED (Type or print) <u>BESSIE KATE ARMACOST COVER</u> First Middle Last				4. DATE OF DEATH <u>JULY 14 1966</u> Month Day Year																																			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 24 1882</u> Year		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>																															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>																															
13. FATHER'S NAME <u>GEORGE W. ARMACOST</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA HERING</u>																																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>220-44-8442</u>		17. INFORMANT <u>MRS. HARRY REESE WESTMINSTER MD</u>																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u>																															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																																							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>										20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>										20f. (City or town) <u>WESTMINSTER</u> (County) <u>MD</u> (State) <u> </u>									
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 14 1966</u> to <u>JULY 14 1966</u> that (I) (we) last saw the deceased alive on <u>JULY 14 1966</u> and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.																																							
22a. SIGNATURE <u>Daniel I Welliver</u> M.D.										22b. DATE SIGNED <u>7-14-66</u>																													
22c. PHYSICIAN'S NAME (Type) <u>DANIEL I. WELLIVER</u>										22d. ADDRESS <u>19 RIDGE ROAD WESTMINSTER, MD</u>																													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>7/16/66</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Kreders Cemetery</u>					23d. LOCATION (City, town or county) <u>Rural Westminster Md.</u> (State) <u>MD</u>																								
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.S. Myeroff, Westminster, Md.</u> ADDRESS <u> </u>										25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>JUL 18 1966</u>										25b. REGISTRAR'S SIGNATURE																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY		CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Westminster		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Westminster	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		27 E. Main St.		d. STREET ADDRESS		27 E. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		HERMAN W. COLLISON		First Middle Last		4. DATE OF DEATH		July 2 19 66	
5. SEX		Male		6. CDOLOR DR RACE		White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH		7/12/12		9. AGE (In years last birthday)		53 yrs.		IF UNDER 1 YEAR Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Road work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Road work						Maryland		USA	
13. FATHER'S NAME		L. Kurtz Cullison		14. MOTHER'S MAIDEN NAME		Estie Wilhelm			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				703-10-7173		Mr. Atlee Cullison		Hampstead, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4201		DUE TO		Cardiac Infarction		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)				minutes	
				(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Maurice C. Porterfield		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type)		acting				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		7-2-66	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Hampstead, Carroll	
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		23b. DATE THEREOF		7/5/66		23c. NAME OF CEMETERY OR CREMATORY	
Burial								Grace Cemetery	
24. FUNERAL DIRECTOR		Tipton-Eline		ADDRESS		Hampstead, Md.		25a. REC'D BY REGISTRAR	
								DATE JUL 7 1966	
								25b. REGISTRAR'S SIGNATURE	
								Charles Judge	

09710

ON THE 10th of May 1944

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09718		09717		
1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN Ib 19 days		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		15-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Route #3		
e. IS RESIDENCE ON A FARM? Unk <input type="checkbox"/> YES <input type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print) First GLADYS Middle OPAL Last DALTON		4. DATE OF DEATH Month July Day 15 Year 19 66		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-06	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Hosea Dalton		14. MOTHER'S MAIDEN NAME Marion (Maiden name unknown)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		
17. INFORMANT Records, Springfield State Hospital		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 201X IMMEDIATE CAUSE (a) Possible Hodgkins Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS with convulsive disorder and psychotic reaction.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6-27-66 , 19 66 to 7-15-66 , 19 66 , that (I) (we) lost saw the deceased alive on 7-15-66 , 19 66 , and that death occurred at 10:40 P.M. from causes and on the date stated above.				
22a. SIGNATURE <i>Carlos G. Lavin</i>		22b. DATE SIGNED 7-15-66		
22c. PHYSICIAN'S NAME (Type) Carlos G. Lavin, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-19-66		
23c. NAME OF CEMETERY OR CREMATORY Sunset View Memorial Park		23d. LOCATION (City or Town) (County) (State) Woodstock VA.		
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.		25a. REC'D BY REGISTRAR DATE JUL 22 1966		
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09713					09718				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Carroll</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> 06-1				
c. LENGTH OF STAY IN 1b <u>1 day</u>					d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last <u>ALICE JANE Davis</u> "A"					Month Day Year <u>JULY 30 1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29 1966</u>		9. AGE (In years last birthday) <u>—</u> yrs. <u>—</u> Months <u>—</u> Days <u>22</u> Hours <u>38</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Westminster, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin L. Davis</u>					14. MOTHER'S MAIDEN NAME <u>Betty Robinson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>					16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Edwin L. Davis</u> Address <u>4 Pool Road Westminster, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>176X Prematurity Imaturity BW 1'4"</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> , 19 <u>66</u> , to <u>7/30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/30</u> , 19 <u>66</u> , and that death occurred at <u>9:55</u> P.M., from the causes and on the date stated above.									
22a. SIGNATURE <u>John S. Harshey</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7/30/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>					22d. ADDRESS <u>8 Archer St. Westminster, Md.</u>				
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>8/1/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salem, W. Va.</u>		
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, Md.</u>					25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE		
DATE <u>AUG 2 1966</u>									

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Robert & Rose
 James White
 Alice Jane
 Carroll Co. House Hospital
 1 day
 Westmonte
 Carroll
 July 29/1914
 Westmonte, Ark. H. 2.4
 July 30 00

Robert & Rose
 James White
 Alice Jane
 Carroll Co. House Hospital
 1 day
 Westmonte
 Carroll
 July 29/1914
 Westmonte, Ark. H. 2.4
 July 30 00

CERTIFICATE OF DEATH

09720

09719

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> 06-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>JANE</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29 1966</u>
9. AGE (In years last birthday) yrs. <u>—</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>1</u> Hours <u>20</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Westminster Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>A.S.A.</u>	
13. FATHER'S NAME <u>Adrian L. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Betty Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Adrian L. Davis</u> Address <u>4 Park Road Westminster Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity B.W. 1'2"</u> 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> , 19 <u>66</u> , to <u>7/30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/30</u> 19 <u>66</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>7/30/66</u>
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>Garfield St. Westminster Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/1/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>F.O.O.F. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Shiloh, W. Va.</u>
24. FUNERAL DIRECTOR <u>J.S. Myers, Jr., Westminster, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 2 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

1-848-3000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their page remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00310

RECEIVED

00310

James J. Brown
MARTIN JANE
July 30 1910
July 29 1910
July 28 1910
July 27 1910
July 26 1910
July 25 1910
July 24 1910
July 23 1910
July 22 1910
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James J. Brown
MARTIN JANE
July 30 1910
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July 11 1910
July 10 1910
July 9 1910
July 8 1910
July 7 1910
July 6 1910
July 5 1910
July 4 1910
July 3 1910
July 2 1910
July 1 1910

09721

CERTIFICATE OF DEATH

09720

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 8yrs. 1mo. 7dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle McCAFFREY Last DILLON		4. DATE OF DEATH Month JULY Day 18 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-1889
9. AGE (In years last birthday) yrs. 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edmund M. Dillon	
14. MOTHER'S MAIDEN NAME Virginia McCaffrey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 122-20-0341		17. INFORMANT Records, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) Generalized arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4221			INTERVAL BETWEEN ONSET AND DEATH Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 6-11-58 , 19 58 , to 7-18-66 , 19 66 , that (I) (we) last saw the deceased alive on 7-18-66 , 19 66 , and that death occurred at 1:45 AM , from causes and on the date stated above.	
22a. SIGNATURE R. G. Lafonchere M.D.		22b. DATE SIGNED 7-18-66	
22c. PHYSICIAN'S NAME (Type) R. G. Lafonchere, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 21, 1966	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	23d. LOCATION (City or Town) (County) (State) Brooklyn, Anne Arundel, Md.
24. FUNERAL DIRECTOR R. V. Singleton		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 22 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03730

03730

CERTIFICATE OF DEATH

3031 W. Belmont St.

Westfield, Massachusetts

WILLIAM H. HOBART

DECEASED

1933-1934

WHITE

MALE

Virginia Halliday

WILLIAM H. HOBART

1933-1934

Year

Year

Chlorophenoxy compound, 2,4-dichlorophenoxy type

1933-1934

1933-1934

1933-1934

E. J. TAYLOR

JUL 2 1934

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09722

09721

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Long View Nursing Home</i>				d. STREET ADDRESS <i>35 Johns St</i>			
3. NAME OF DECEASED (Type or print) First <i>DAISY</i> Middle <i>L</i> Last <i>ECKARD</i>				4. DATE OF DEATH Month <i>July</i> Day <i>30</i> Year <i>1966</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 13, 1890</i>	9. AGE (In years last birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months <i></i> Days <i></i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Carroll Co. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Samuel Carr</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Smith</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-24-1297D</i>		17. INFORMANT <i>Charles Dotson, Westminster, Md</i> Address <i></i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Arterio. Sclerosis</i> (c) <i></i> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>Unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetic Mellitus</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 16, 1966</i> to <i>July 30, 1966</i> , that (I) (we) last saw the deceased alive on <i>July 29, 1966</i> , and that death occurred at <i>10:15 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Maurice C. Porterfield</i> M.D.				22b. DATE SIGNED <i>July 30, 1966</i>			
22c. PHYSICIAN'S NAME (Type) <i>MAURICE C. PORTERFIELD</i>				22d. ADDRESS <i>HAMPSTEAD, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/2/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rivers Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Rural Westminster, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Jr., Westminster, Md.</i> ADDRESS <i></i>				25. REC'D BY REGISTRAR <i>Charles Judge</i> DATE <i>AUG 2 1966</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1978

03723

218-14-1412

FRANCIS C. PORTER

9/10/10 Richard County, Iowa
L. J. Porter, Jr. 218-14-1412

CERTIFICATE OF DEATH

09722

09722

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Uniontown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Eugene Eckenrode				4. DATE OF DEATH Month Day Year July 18, 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1877		9. AGE (In years last birthday) yrs. 89	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George A. Eckenrode				14. MOTHER'S MAIDEN NAME Annie Reaver			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Clarence Lockard, Uniontown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Generalized arteriosclerosis (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 5, 1966 to July 18, 1966 , that (I) (we) last saw the deceased alive on July 18, 1966 , and that death occurred at 5:33 M, from causes and on the date stated above.							
22a. SIGNATURE John S. Harshey				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/18/66	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.				22d. ADDRESS Anchor St. Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 20, 1966		23c. NAME OF CEMETERY OR CREMATORY Church of God Cemetery		23d. LOCATION (City or Town) (County) (State) Uniontown, Maryland	
24. FUNERAL DIRECTOR John H. Skiles				25a. REC'D BY REGISTRAR C.O. Fuss & Son, Taneytown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

55524

552

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
097224 CERTIFICATE OF DEATH 09723											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
c. LENGTH OF STAY IN 1b <u>3 yrs.</u>						d. STREET ADDRESS <u>3410 Dupont Ave</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hosp.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Sophia</u> Middle <u>Miriam</u> Last <u>Feldman</u>						4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>19 66</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>XXXXXXXXXX</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Michael Stofbey</u>						14. MOTHER'S MAIDEN NAME <u>Toby Gedel/Nih</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>MRS. BELLEKLINE 3902 BUCKINGHAM ROAD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterioscerotic Heart Disease</u> <u>4200</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> yrs. <u> </u> Years <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>63</u> , to <u>July 8</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 8</u> , 19 <u>66</u> , and that death occurred at <u>9P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>R. S. Glahn</u>										22b. DATE SIGNED <u>7-9-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rita S. Glahn</u>						22d. ADDRESS <u>Springf. State Hosp.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/10/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ANSHE EMUNAH AITZ CHAIM</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MARYLAND</u>					
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.</u>						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09725

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09724

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b 45 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 178 Penna. Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster d. STREET ADDRESS 178 Penna. Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MILDRED NAOMI FISHPAUGH			4. DATE OF DEATH Month July Day 10 Year 19 66				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1913	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 06 Days 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife and sewing factory		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Eastview, Carroll Co.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel Seipp			14. MOTHER'S MAIDEN NAME Joanna Deagen				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Walter L. Seipp Address 81 Bond Street Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) Alcoholism OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH Sudden 3-4 yrs		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Walter L. Seipp		M.O. Walter L. Seipp		22. DATE SIGNED 7-14-66			
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7/13/66		23c. NAME OF CEMETERY OR CREMATORY Krider's Cemetery			
23d. LOCATION (City, town, or county)		Westminster, RD, Md.					
24. FUNERAL DIRECTOR J.E. Myers, Jr., Westminster, Md.		ADDRESS		25a. REC'D BY REGISTRAR JUL 14 1966			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from the certificate, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (1)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09726

CERTIFICATE OF DEATH

09725

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b 60 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. Gen. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster d. STREET ADDRESS 106 Uniontown Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BELLE FRANKLIN		4. DATE OF DEATH Month 7 Day 15 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/90
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwf.		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Campbell		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-24-8224	
17. INFORMANT Mr. Vinard Franklin, Manchester, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA DUE TO (b) 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 1 WEEK		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIO SCLEROTIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/9 , 1966, to 7/15 , 1966, that (I) (we) last saw the deceased alive on 7/14 1966, and that death occurred at 4:30 M, from causes and on the date stated above.			
22a. SIGNATURE Vinard J. Franklin Jr.		22b. DATE SIGNED 7/15/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/18/66	
23c. NAME OF CEMETERY OR CREMATORY Millers Cemetery		23d. LOCATION (City or Town) (County) (State) Carroll Co. Md.	
24. FUNERAL DIRECTOR Tipton-Eline		25a. REC'D BY REGISTRAR Hampstead, Md.	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE JUL 21 1966	

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ASSOCIATION

09727

CERTIFICATE OF DEATH

09726

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 16 1yr. 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 2913 Cresmont Avenue	
3. NAME OF DECEASED (Type or print) First ELENOA Middle MATHILDA Last GEIGES		4. DATE OF DEATH Month July Day 13 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-82
9. AGE (In years) 83 (last birthday) yrs.		10. IF UNDER 1 YEAR Months 1 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sophus Ogendahl		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records		Address Sykesville Springfield State Hospital Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) Chronic brain syndrome associated with cerebral arteriosclerosis DUE TO (c) Chronic brain syndrome associated with senile brain disease with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with senile brain disease with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-30- , 19 65 , to 7-13- , 19 66 , that (I) (we) last saw the deceased alive on 7/13 , 19 66 , and that death occurred at 12:35 P.M. from causes and on the date stated above.			
22a. SIGNATURE S. P. Wise III, M.D.		22b. DATE SIGNED 7-13-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 16, 1966	23c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery	23d. LOCATION (City or Town) (County) (State) Bloomfield New Jersey
24. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.		25a. REC'D BY REGISTRAR 1217 St. Paul Street	
25b. REGISTRAR'S SIGNATURE JUL 15 1966		25c. REGISTRAR'S SIGNATURE Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
097228													
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Long View Nursing Home Inc</u>						d. STREET ADDRESS <u>61, W Main Street</u>							
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>ANN</u> Last <u>Goodwin</u>						4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1966</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 3, 1884</u>		9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>				11. BIRTHPLACE (County & State, or foreign country) <u>London England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>UNKNOWN — POWELL</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>215-20-9616</u>						17. INFORMANT <u>Charles Byers</u> Address <u>Carroll Street Westminster</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Vascular Disease</u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that (1) (this hospital) attended the deceased from <u>3/19/1966</u> to <u>7/4/1966</u> , that (1) (we) last saw the deceased alive on <u>7/3/1966</u> and that death occurred at <u>9:45</u> AM, from the causes and on the date stated above.													
22a. SIGNATURE <u>W.H. Foard</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/4/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>W. H Foard M.D.</u>						22d. ADDRESS <u>Manchester, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEN.</u>				23d. LOCATION (City, town or county) <u>WESTMINSTER MD.</u> (State) <u> </u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>James G. Saffell Jr.</u>						ADDRESS <u>WESTMINSTER</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Item 2 Film G379 8/8/66 mh

09723

CERTIFICATE OF DEATH

09728

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b Byrs. 6mos. 21dys. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 21502	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 725 Bedford St. Allegany County Infirmary	
3. NAME OF DECEASED (Type or print) IRENE MAY HAINES		4. DATE OF DEATH Month JULY Day 28 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-92
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 28 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Asa Shanholtz		14. MOTHER'S MAIDEN NAME Katie (Maiden name unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal failure DUE TO (c) Nephrosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Weeks Weeks Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-7-63 , 19__, to 7-28-66 , 19__, that (I) (we) last saw the deceased alive on 7-28-66 , 19__, and that death occurred at 8:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Antonius Glahn, M.D.		22b. DATE SIGNED 7-28-66	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 31, 1966	
23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR Knight Funeral Home		25a. REC'D BY REGISTRAR CUMBERLAND, MD.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 4 1966	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09730

CERTIFICATE OF DEATH

09729

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville, Md.		c. LENGTH OF STAY IN 1b OM 8days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor 21776		d. STREET ADDRESS Maple Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Oliver Last Haines		4. DATE OF DEATH Month 7 Day 14 Year 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-28-88
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months 7 Days 14 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wesley Haines		14. MOTHER'S MAIDEN NAME Laura Nusbaum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-10-7005	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular Failure DUE TO Arteriosclerotic Cardiovascular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) years (c)		INTERVAL BETWEEN ONSET AND DEATH hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome, associated with senile brain disease with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour o.m. --- p.m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7-6 , 19 66 , to 7-14 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7-14 , 19 66 , and that death occurred at 9 p. M, from causes and on the date stated above.			
22a. SIGNATURE Heinz H. Klaatsch, M.D.		22b. DATE SIGNED 7-15-66	
22c. PHYSICIAN'S NAME (Type) Heinz H. Klaatsch, M.D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-17-66	
23c. NAME OF CEMETERY OR CREMATORY PRESBYTERIAN CEM.		23d. LOCATION (City or town) (County) (State) NEW WINDSOR MD	
24. FUNERAL DIRECTOR W. B. Bantler & Sons		25a. REC'D BY REGISTRAR NEW WINDSOR	
25b. REGISTRAR'S SIGNATURE W. B. Bantler & Sons		DATE JUL 19 1966	

00730

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CERTIFICATE OF DEATH

Carroll

New York

Carroll

(Burial) Springfield, N.Y. 10 days

New Windsor

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Springfield State Hospital

1000 Avenue

William

Oliver

Rainer

Male

White

1-2-38

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Import

New York

John Wesley White

Laura M. White

no

1970-1971

Hospital records

late September 1971

Springfield State Hospital

Ontario State Hospital, Springfield, N.Y.

Springfield State Hospital, Springfield, N.Y.

1970-1971

1970-1971

1970-1971

John H. White, N.Y.

Springfield State Hospital

1970-1971

09731

CERTIFICATE OF DEATH

09730

1. PLACE OF DEATH COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 128 N. Main St.		d. STREET ADDRESS 128 N. Main St.	
3. NAME OF DECEASED (Type or print) First Jacob Middle Howard Last Hale		4. DATE OF DEATH Month 7 Day 27 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/99
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months 06 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector of acc'ts. Railroad		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Hale		14. MOTHER'S MAIDEN NAME Laura Alban	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Anna Hale		Address Hampstead, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) CH of lung DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 10 d
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/3 , 19 66 to 1/27 , 19 66 , that (I) (we) last saw the deceased alive on 1/24 , 19 66 , and that death occurred at 3:40 M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) [Signature]		22d. ADDRESS Greenmount, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/29/66	23c. NAME OF CEMETERY OR CREMATORY Hampstead	23d. LOCATION (City or Town) (County) (State) Hampstead Md.
24. FUNERAL DIRECTOR Tipton-Eline		25a. REC'D BY REGISTRAR DATE AUG 2 1966	
ADDRESS Hampstead, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last LOUISE ESTELLA HARRIS					4. DATE OF DEATH Month Day Year 7 11 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/30/81		9. AGE (In years last birthday) 84 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWF				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Jacob Rider					14. MOTHER'S MAIDEN NAME Christine Miller					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. 213-30-2030A					
17. INFORMANT Mr. T. E. Harris					Address Hampstead, Md.					
18. CAUSE OF DEATH [Enter only one cause-per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9040 Congestive Heart Failure DUE TO (b) Arteriosclerosis, General with Hypertension and Vascular DUE TO (c) Hypertension & fibrillation Fractured neck & Femur									INTERVAL BETWEEN ONSET AND DEATH 10 yrs 7-4-66	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell in kitchen at home					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7-4 1966					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hampstead Carroll Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE W. E. Peicher					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					Address (Street, city, town or county) Westminster Carroll					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/14/66		23c. NAME OF CEMETERY OR CREMATORY Immanuel Lutheran			23d. LOCATION (City, town or county) Baltimore Md.		
24. FUNERAL DIRECTOR Tipton-Eline Fun.Home, Hampstead, Md.					25a. REC'D BY REGISTRAR JUL 15 1966					
					25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

09733

CERTIFICATE OF DEATH

09732

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 30yr.5mo.13dys. Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Beachwood & Sherwood Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last MARY ELIZABETH HAVILAND		4. DATE OF DEATH Month Day Year July 11 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-07
9. AGE (In years lost birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Ross Leonard		14. MOTHER'S MAIDEN NAME Janey Leonard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infected burns, 1st and 2nd degree DUE TO (c) Schizophrenic reaction, paranoid type.			
19. INTERVAL BETWEEN ONSET AND DEATH days weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Found on 6-24-66 to have blisters on both feet & toes & according to patient she got in hot water.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year noticed 6-24-66 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that (I) (this hospital) attended the deceased from 2-28-36 to 7-11-66 , 19__, that (I) (we) last saw the deceased alive on 7-11-66 19__, and that death occurred at 9:10 A.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Antonius Glahn, M.D.		22b. DATE SIGNED 7-11-66	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-15-66	
23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Md	
24. FUNERAL DIRECTOR Harry W. Haight		25a. REC'D BY REGISTRAR DATE JUL 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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OFFICE OF THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
09734			CERTIFICATE OF DEATH		
09733					
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville		c. LENGTH OF STAY IN lb Oy Om 16d		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 21217 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 626 Baker Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Alonzo Middle (NMN) Last Hill			4. DATE OF DEATH Month 7 Day 8 Year 19 66		
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-12-00	9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME William Hill		12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic Coma DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH minutes hours history			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome, cerebral arteriosclerosis with psychotic reaction.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --			
20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. -- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --	
20f. (City or town) --		20g. (County) --		20h. (State) --	
21. I certify that he (this hospital) attended the deceased from 6-22 , 19 66 , to 7-8 , 19 66 , that (X) (we) last saw the deceased alive on 7-8 , 19 66 , and that death occurred on 4 A.M. , from causes and on the date stated above.					
22a. SIGNATURE <i>[Signature]</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-8-66	
22c. PHYSICIAN'S NAME (Type) A. Arengo, M.D.		22d. ADDRESS Springfield State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 12, 1966		23c. NAME OF CEMETERY OR CREMATORY Moses Cemetery	
23d. LOCATION (City or Town) Baltimore, Md.		23e. (County) Md.		23f. (State) Md.	
24. FUNERAL DIRECTOR Joseph L. Kues		ADDRESS 2222 W. North Ave		25a. REC'D BY REGISTRAR JUL 13 1966	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

03733

STATE OF OHIO

03734

Name		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Income		Assets		Liabilities		Notes	
John Doe		35		Male		White		Catholic		Married		Teacher		High School		\$10,000		\$50,000		\$20,000			
Jane Smith		28		Female		White		Protestant		Single		Nurse		College		\$8,000		\$40,000		\$15,000			
Robert Johnson		42		Male		Black		Baptist		Divorced		Farmer		High School		\$12,000		\$60,000		\$25,000			
Mary White		30		Female		White		Methodist		Married		Homemaker		High School		\$6,000		\$30,000		\$10,000			
David Brown		25		Male		White		Jewish		Single		Student		College		\$4,000		\$20,000		\$5,000			
Susan Green		38		Female		White		Anglican		Married		Manager		College		\$9,000		\$45,000		\$18,000			
Michael Black		22		Male		Black		Muslim		Single		Worker		High School		\$3,000		\$15,000		\$4,000			
Emily Davis		32		Female		White		Lutheran		Married		Teacher		College		\$7,000		\$35,000		\$12,000			
Christopher Lee		27		Male		White		Catholic		Single		Engineer		College		\$11,000		\$55,000		\$22,000			
Amanda Wilson		29		Female		Black		Buddhist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Daniel Taylor		33		Male		White		Anglican		Divorced		Manager		College		\$10,000		\$50,000		\$20,000			
Nicole Anderson		26		Female		White		Jewish		Single		Student		College		\$5,000		\$25,000		\$6,000			
Kevin Thomas		31		Male		Black		Muslim		Married		Worker		High School		\$4,000		\$20,000		\$5,000			
Olivia Martinez		34		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Nathan Garcia		23		Male		White		Protestant		Single		Student		College		\$3,000		\$15,000		\$4,000			
Sophia Hernandez		36		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Liam King		24		Male		White		Jewish		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Isabella Lopez		37		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Ethan Scott		21		Male		Black		Muslim		Single		Student		College		\$3,000		\$15,000		\$4,000			
Mia Adams		39		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Caleb Baker		28		Male		White		Protestant		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Aria Nelson		30		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Grayson Hill		25		Male		White		Jewish		Single		Student		College		\$5,000		\$25,000		\$6,000			
Luna Young		32		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Julian Allen		22		Male		Black		Muslim		Single		Worker		High School		\$3,000		\$15,000		\$4,000			
Savannah King		35		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Miles Wright		27		Male		White		Protestant		Single		Student		College		\$4,000		\$20,000		\$5,000			
Valentina Lopez		38		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Carter Hill		23		Male		White		Jewish		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Nora Young		31		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Elijah King		24		Male		Black		Muslim		Single		Student		College		\$3,000		\$15,000		\$4,000			
Ariana Adams		33		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Gabriel Baker		26		Male		White		Protestant		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Lyla Nelson		34		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Jaxon Hill		21		Male		White		Jewish		Single		Student		College		\$5,000		\$25,000		\$6,000			
Mila Young		36		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Kai King		25		Male		Black		Muslim		Single		Worker		High School		\$3,000		\$15,000		\$4,000			
Serenity Lopez		32		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Miles Young		27		Male		White		Protestant		Single		Student		College		\$4,000		\$20,000		\$5,000			
Valentina King		39		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Carter Adams		23		Male		White		Jewish		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Nora Baker		31		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Elijah Lopez		24		Male		Black		Muslim		Single		Student		College		\$3,000		\$15,000		\$4,000			
Ariana Hill		33		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Gabriel Young		26		Male		White		Protestant		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Lyla King		34		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Jaxon Adams		21		Male		White		Jewish		Single		Student		College		\$5,000		\$25,000		\$6,000			
Mila Lopez		36		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Kai Young		25		Male		Black		Muslim		Single		Worker		High School		\$3,000		\$15,000		\$4,000			
Serenity King		32		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Miles Lopez		27		Male		White		Protestant		Single		Student		College		\$4,000		\$20,000		\$5,000			
Valentina Adams		39		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Carter Lopez		23		Male		White		Jewish		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Nora Hill		31		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Elijah Adams		24		Male		Black		Muslim		Single		Student		College		\$3,000		\$15,000		\$4,000			
Ariana Lopez		33		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Gabriel Adams		26		Male		White		Protestant		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Lyla Lopez		34		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Jaxon Adams		21		Male		White		Jewish		Single		Student		College		\$5,000		\$25,000		\$6,000			
Mila Lopez		36		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Kai Adams		25		Male		Black		Muslim		Single		Worker		High School		\$3,000		\$15,000		\$4,000			
Serenity Lopez		32		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Miles Adams		27		Male		White		Protestant		Single		Student		College		\$4,000		\$20,000		\$5,000			
Valentina Lopez		39		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Carter Adams		23		Male		White		Jewish		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Nora Lopez		31		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Elijah Adams		24		Male		Black		Muslim		Single		Student		College		\$3,000		\$15,000		\$4,000			
Ariana Lopez		33		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Gabriel Adams		26		Male		White		Protestant		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Lyla Lopez		34		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Jaxon Adams		21		Male		White		Jewish		Single		Student		College		\$5,000		\$25,000		\$6,000			
Mila Lopez		36		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Kai Adams		25		Male		Black		Muslim		Single		Worker		High School		\$3,000		\$15,000		\$4,000			
Serenity Lopez		32		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Miles Adams		27		Male		White		Protestant		Single		Student		College		\$4,000		\$20,000		\$5,000			
Valentina Lopez		39		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Carter Adams		23		Male		White		Jewish		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Nora Lopez		31		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Elijah Adams		24		Male		Black		Muslim		Single		Student		College		\$3,000		\$15,000		\$4,000			
Ariana Lopez		33		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Gabriel Adams		26		Male		White		Protestant		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Lyla Lopez		34		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Jaxon Adams		21		Male		White		Jewish		Single		Student		College		\$5,000		\$25,000		\$6,000			
Mila Lopez		36		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Kai Adams		25		Male		Black		Muslim		Single		Worker		High School		\$3,000		\$15,000		\$4,000			
Serenity Lopez		32		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Miles Adams		27		Male		White		Protestant		Single		Student		College		\$4,000		\$20,000		\$5,000			
Valentina Lopez		39		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			
Carter Adams		23		Male		White		Jewish		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Nora Lopez		31		Female		White		Anglican		Married		Manager		College		\$10,000		\$50,000		\$20,000			
Elijah Adams		24		Male		Black		Muslim		Single		Student		College		\$3,000		\$15,000		\$4,000			
Ariana Lopez		33		Female		White		Catholic		Married		Teacher		College		\$9,000		\$45,000		\$18,000			
Gabriel Adams		26		Male		White		Protestant		Single		Worker		High School		\$4,000		\$20,000		\$5,000			
Lyla Lopez		34		Female		Black		Baptist		Married		Nurse		College		\$8,000		\$40,000		\$16,000			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09735

09734

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 2834 Maryland Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND CHESTER HILL, Sr.		4. DATE OF DEATH Month Day Year July 9, 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-94
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (retired)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman Hill		14. MOTHER'S MAIDEN NAME Adelaide VanMatter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) yes W W I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc with cerebral arteriosclerosis with psychotic reaction			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-18-66 , 19__, to July 9 , 19 66 , that (I) (we) last saw the deceased alive on 7-9-66 , 19__, and that death occurred at __ M, from causes and on the date stated above.			
22a. SIGNATURE Edward R. Acle		22b. DATE SIGNED 7-9-66	
22c. PHYSICIAN'S NAME (Type) Edward R. Acle, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/13/66	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202		25a. REC'D BY REGISTRAR DATE JUL 13 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00738

CERTIFICATE OF BIRTH

00738

Name of Child		Date of Birth	
John Doe		1900-01-01	
Place of Birth		City of New York	
Parents		John Doe and Jane Doe	
Signature of Registrar		[Signature]	
Date of Issuance		1900-01-01	
Official Seal		[Seal]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

09736

CERTIFICATE OF DEATH

09735

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 9mos.27dys.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3332 Dolfield Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SAMUEL Middle (NMN) Last HIRSCH		4. DATE OF DEATH Month JULY Day 20 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-16-1895
9. AGE (In years lost birthday) yrs. 70		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owned grocery store		10b. KIND OF BUSINESS OR INDUSTRY Bremen, Germany	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-32-8212	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 446X IMMEDIATE CAUSE (a) Uremia DUE TO (b) Nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Chronic brain syndrome assoc. with cerebral arteriosclerosis, with psychotic reaction		INTERVAL BETWEEN ONSET AND DEATH Days Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-23-65 , 19__, to 7-20-66 , 19__, that (I) (we) last saw the deceased alive on 7-20-66 , 19__, and that death occurred at 4:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 7-20-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/21/66	23c. NAME OF CEMETERY OR CREMATORY Rosedale	23d. LOCATION (City or Town) (County) (State) Balto Md
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc		25a. REC'D BY REGISTRAR DATE JUL 22 1966	
ADDRESS 33140 Olympia Ave		25b. REGISTRAR'S SIGNATURE Charles Judge	

05200

35120

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2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY CARROLL					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL FINKSBURG				c. LENGTH OF STAY IN 1b 45 YRS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL, FINKSBURG				d. STREET ADDRESS 06-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First ELUIE Middle MAUDE Last HUGHES						4. DATE OF DEATH Month JULY Day 19 Year 1966					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 14, 1894		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) CARROLL CO, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FRANK E. HARRY						14. MOTHER'S MAIDEN NAME CLARA E. STRICKER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 216-38-2554		17. INFORMANT Address Howard C. Hughes, Finksburg RT#2 Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS											
332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO GENERALIZED ARTERIOSCLEROSIS DUE TO DIABETES MELLITUS											
INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 10 YRS 5 YRS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF BLADDER 1 YR											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/12/66 to 7/19/66 , that (I) (we) last saw the deceased alive on 7/18/66 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE William L. Stewart, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 7/19/66		
22c. PHYSICIAN'S NAME (Type) William L. Stewart, M.D.						22d. ADDRESS 19 RIDGE RD. WESTMINSTER, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/22/66		23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery Finksburg RT#2 Md.				23d. LOCATION (City, town or county) (State) Finksburg RT#2 Md.			
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Myers, Jr., Westminster, Md.						ADDRESS Westminster, Md.		25a. REC'D BY REGISTRAR J. Charles Judge		25b. REGISTRAR'S SIGNATURE J. Charles Judge	
DATE JUL 22 1966											

00738

CERTIFICATE OF DEATH

00738

Blank certificate form with faint horizontal lines and two punch holes on the right side.

09738

CERTIFICATE OF DEATH

09737

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY in 1b <u>11 days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21217</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>215 N. Freemont Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Virginia Lee</u> Last <u>HYMAN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>19 66</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>SEPARATED</u> <input checked="" type="checkbox"/> <u>Divorced</u>	8. DATE OF BIRTH <u>5/14/22</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rufus Lee - dec.</u>		14. MOTHER'S MAIDEN NAME <u>Willie Mae Peters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-20-6646</u>	
17. INFORMANT <u>Springfield State Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary insufficiency</u> DUE TO (b) <u>Far advanced Pulmonary Tuberculosis</u> DUE TO (c) <u>10021</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic reaction, paranoid type.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-4-63</u> , 19 <u>63</u> to <u>7-15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-15-66</u> , 19 <u>66</u> , and that death occurred at <u>8:20 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Carlos G. Lavin</u>		22b. DATE SIGNED <u>7-15-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Carlos G. Lavin, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital Sykesville, Maryland 21784</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/20/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cemetry</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>Adolphus Halstead</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>JUL 20 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00373

00373

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, WASHINGTON, D. C.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

09739

CERTIFICATE OF DEATH

11203

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

12
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 9mos. 1dy.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1135 Parrish St.	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ERNEST Last JAMES		4. DATE OF DEATH Month JULY Day 23 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-1894
9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR Months 10 Days 23 Hours 45 Min. 44	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-26-7178	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-22-65 to 7-23-66 , 19____, that (I) (we) last saw the deceased alive on 7-23-66 19____, and that death occurred at 10:45 A.M. on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 7-25-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY M. of M. Anatomy Board		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Newell Funeral Home, Pikesville - 524		25. REC'D BY REGISTRAR 10 AUG 9 1966	
25a. REGISTRAR'S SIGNATURE Charles Young			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

09740

CERTIFICATE OF DEATH

09738

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 5y. 7m. 6d.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3c. 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 640 E. Clement Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Helen Elizabeth Jett		4. DATE OF DEATH Month Day Year 7 19 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/09
9. AGE (In years last birthday) yrs. 57		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Jett		14. MOTHER'S MAIDEN NAME Annie Norfolk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Springfield Hospital records, Sykesville		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 2865 DUE TO (b) Malnutrition DUE TO (c) Inanition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH days years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 12/13/ 1960 , to 7/19/ 1966 , that we (we) last saw the deceased alive on 7/19/ 1966 , and that death occurred at 7:30 a.m. from causes and on the date stated above.			
22a. SIGNATURE Edmee J. Reeves		22b. DATE SIGNED 7/20/66	
22c. PHYSICIAN'S NAME (Type) Edmee J. Reeves, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7.22.66	
23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Newell Funeral Home Pikesville		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 26 1966	

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UNITED STATES OF AMERICA

00782

Control

Kerryland

Initiations

No. 62.

Kerryland

620 E. Clement Street

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN lb <u>1da</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>725 Kelly Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph William Kelley</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-21-17</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. BIRTHPLACE (County & State, or foreign country) <u>Maryland Cumberland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elect. Contr.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Cumberland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Joseph Kelley</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Violet Kerns</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes, W. W. # 2</u>		16. SOCIAL SECURITY NO. <u>220-10-4364</u>	
17. INFORMANT <u>Hospital Record, Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Ventricular failure</u> DUE TO <u>Chronic Pulmonary insufficiency</u> (b) <u>TB Old</u> (c) <u>TB Old</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Alcoholic Addiction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 8</u> , 19 <u>66</u> , to <u>July 9</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>7-9-66</u> , 19 <u>66</u> , and that death occurred at <u>11:00M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Octavio A. Ruiz</u>		22b. DATE SIGNED <u>7-9-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Octavio A. Ruiz, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/13/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany Md.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 13 1966</u>	
ADDRESS <u>Cumberland, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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STATEMENT OF DEBIT

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TO CREDIT BALANCE WITH INCREASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
09742																	
09740																	
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middleburg</u> c. LENGTH OF STAY IN 1b <u>Brookfield Manor Nurs. Home</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>M.</u> Middle <u>Leese</u> Last			4. DATE OF DEATH <u>7</u> Month <u>21</u> Day <u>19</u> Year <u>66</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>								
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>11-3-88</u>			9. AGE (In years last birthday) <u>77</u> yrs.			10. IF UNDER 1 YEAR Months <u>7</u> Days <u>21</u>		11. IF UNDER 24 HRS. Hours <u>19</u> Min. <u>66</u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Charles W. Leese</u>						14. MOTHER'S MAIDEN NAME <u>Jane Hale</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>218-32-4517</u>						17. INFORMANT <u>Mr. Harry Leese, Valley View, Penna.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO <u>Cerebral atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral atherosclerosis</u> (c) <u>Diabetes Mellitus</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Several weeks</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>7/14/66</u> , 19 <u>66</u> , to <u>7/21/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/21/66</u> , 19 <u>66</u> , and that death occurred at <u>2:45</u> PM, from the causes and on the date stated above.																	
22a. SIGNATURE <u>[Signature]</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <u>7/21/66</u>					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>7/23/66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Manchester Md.</u>								
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Dipton - Eline, Hampstead, Md.</u>						25a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>JUL 26 1966</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>								

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09743

CERTIFICATE OF DEATH

09741

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main St.			d. STREET ADDRESS 108 S. Main St.		
3. NAME OF DECEASED (Type or print) First Middle Last LESSLEY E. LEPP0			4. DATE OF DEATH Month Day Year 7 15 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/94		9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodworker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Jesse Leppo			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 212-18-4311A		
17. INFORMANT Mrs. Sarah A. Leppo, Manchester, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 154X Carcinoma of rectum with metastases IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/15 , 19 65 to 7/15 , 19 66 , that (I) (we) last saw the deceased alive on 7/15 , 19 66 , and that death occurred at 5:30 AM, from causes and on the date stated above.					
22a. SIGNATURE D.A. Knight MD			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) D.A. Knight MD			22d. ADDRESS Greenmount, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/18/66	23c. NAME OF CEMETERY OR CREMATORY Manchester		23d. LOCATION (City or Town) (County) (State) Manchester Md.
24. FUNERAL DIRECTOR Tipton-Eline			ADDRESS Hampstead, Md.		25a. REC'D BY REGISTRAR DATE JUL 21 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician. Page 2 of 3 should be retained by the funeral director. Page 3 of 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
09744											
09742											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN 1b <u>8 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Long View Nursing Home Inc</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Delaware</u> b. COUNTY <u>NEW CASTLE Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wilmington (BELLEFONTE)</u> d. STREET ADDRESS <u>601, Grand View Ave</u> 46-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>EV A</u> First <u>E</u> Middle <u>LEVEY</u> Last						4. DATE OF DEATH <u>July 29</u> 19 <u>66</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 18, 1881</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Andalusia Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Allen Baer Eckerl-</u>						14. MOTHER'S MAIDEN NAME <u>Emma Elizabeth Brown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>221-36-0569</u>		17. INFORMANT <u>Jane Ricketts</u> Address <u>Finksburg, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic C-V Disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>General Arterio-Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____										INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>5-26-66</u> to <u>July 29, 66</u> , that (I) (we) last saw the deceased alive on <u>July 27, 1966</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Maurice C. Porterfield</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 29, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Maurice C. Porterfield MD</u>						22d. ADDRESS <u>Hampstead, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/1/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Christiana mth. Cemetary</u>		23d. LOCATION (City, town or county) <u>Christiana, Delaware</u> (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr., Westminster, Md.</u> ADDRESS _____						25a. REC'D BY REGISTRAR <u>AUG 1 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

09798

CERTIFICATE OF DEATH

09798



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09745

09743

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester Md.</u> c. LENGTH OF STAY in 1b <u>4 weeks</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Adams Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u> d. STREET ADDRESS <u>231 Frederick St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>MAUDE</u> First <u>N</u> Middle <u>LIPPY</u> Last			4. DATE OF DEATH <u>July 18</u> Month <u>July</u> Day <u>18</u> Year <u>1966</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/3/1888</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>The Family Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Adams Co. Pa.</u>	
13. FATHER'S NAME <u>Augustus Lippy</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hook</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Rodney P. Neiderer, Hanover, Pa.</u> Address <u>R. D. 4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Osteolytic Ca of hip & knee</u> 159X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper V.I. Cancer - to Achromatosis</u> DUE TO (c) <u>Indefinite</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 16</u> 19 <u>66</u> to <u>7-18</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 18</u> 19 <u>66</u> , and that death occurred at <u>8:59</u> A.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>Maurice C. Porterfield</u> M.D.			22b. DATE SIGNED <u>July 8, 1966</u>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS <u>Hampstead, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>	
23d. LOCATION (City, town or county) <u>Nr. Littlestown, Adams Co. Pa.</u>		23e. REC'D BY REGISTRAR <u>Charles Judge</u>		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little, Littlestown, PA</u>		24a. ADDRESS		24b. DATE <u>JUL 21 1966</u>	

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Johnny R. Johnson, Hanover, Pa. A. D. 4

Hanover, Pa.

Mr. Johnston, Adams Co. Pa.

July 1, 1908

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09746

CERTIFICATE OF DEATH

09744

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6 mos. 6 dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle WESLEY Last LOCKNER		4. DATE OF DEATH Month July Day 5 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-74
9. AGE (In years last birthday) 92 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wesley Lockner		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
INTERVAL BETWEEN ONSET AND DEATH days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-29-65 , 19__ to 7-5-66 , 19__, that (I) (we) lost saw the deceased alive on 7-5-66 , 19__, and that death occurred at 11:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 7-5-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/8/66	
23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S		23d. LOCATION (City or Town) (County) (State) BALTO, MD.	
24. FUNERAL DIRECTOR Paul E. Chronette		25a. REC'D BY REGISTRAR DATE JUL 8 1966	
ADDRESS 3617 Chestnut Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
09747					09745					
1. PLACE OF DEATH a. COUNTY <i>CARROLL</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>BALT. City 31</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>			c. LENGTH OF STAY IN 1b <i>22 yrs. 9 months</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>			30-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Springfield State Hosp.</i>					d. STREET ADDRESS <i>502 S. ANN St.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>P.</i> Last <i>MANTIK</i>			4. DATE OF DEATH Month <i>7</i> Day <i>23</i> Year <i>1966</i>							
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-5-09</i>		9. AGE (In years last birthday) <i>57</i> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>OIL-TANKER-</i>		11. BIRTHPLACE (County & State, or foreign country) <i>NEW ORLEANS-LOUISIANA</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>FRANK MANTIK</i>					14. MOTHER'S MAIDEN NAME <i>STELLA WOZMIAK</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>UNKNOWN - NO -</i>			16. SOCIAL SECURITY NO. <i>218,091,649</i>		17. INFORMANT Address <i>Springfield Records</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Heart Failure</i> <i>260X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Diabetes Mellitis</i>									INTERVAL BETWEEN ONSET AND DEATH <i>MIN'S</i> <i>YEARS</i> <i>YEARS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Schizophrenic Reaction - PARANOID Type (CHRONIC)</i>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>10-30</i> , 19 <i>43</i> , to <i>7-23</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>7-23</i> , 19 <i>66</i> , and that death occurred at <i>3:45 AM</i> , from the causes and on the date stated above.										
22a. SIGNATURE <i>R. C. Lajonchere MD</i>								22b. DATE SIGNED <i>7-23-66</i>		
22c. PHYSICIAN'S NAME (Type) <i>R. C. LAJONCHERE</i>					22d. ADDRESS <i>Springfield Hosp. Sykesville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>26 July 66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cem</i>			23d. LOCATION (City, town or county) (State) <i>6501 Boston St. Balto</i>		
24. FUNERAL DIRECTOR <i>Marie E. Halkowski Balto 24 Md</i>					25a. REC'D BY REGISTRAR DATE <i>JUL 26 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
<i>1000 S. KENWOOD AVE</i>										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
09743 CERTIFICATE OF DEATH 09746											
Items 7, 9 Film G378 7/15/66 mb											
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA CO</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Golden Age Guest Home</i>						d. STREET ADDRESS <i>5 Cecil Rd</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Margaret March</i>		First		Middle		Last		4. DATE OF DEATH <i>July 9 19 66</i>		Day Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov 22, 1883</i>		9. AGE (In years last birthday) <i>82 1/2</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Peter Finger</i>						14. MOTHER'S MAIDEN NAME <i>UnK</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201 Coronary occlusion</i> DUE TO (b) <i>Ch Hypertension</i> DUE TO (c) <i>Gen Arteriosclerosis</i>										INTERVAL BETWEEN ONSET AND DEATH <i>3 da</i> <i>?</i> <i>?</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>June 24, 1966</i> to <i>July 9, 1966</i> that (I) (we) last saw the deceased alive on <i>July 9, 1966</i> , and that death occurred at <i>7:45 PM</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>M N MASTIN</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>July 10 66</i>	
22c. PHYSICIAN'S NAME (Type) <i>M N MASTIN</i>						22d. ADDRESS <i>Westminster Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>7/14/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Vahalla Crematorium</i>				23d. LOCATION (City, town or county) (State) <i>St. Louis Mo</i>			
24. FUNERAL DIRECTOR <i>McCully FH 237 Patapsco Ave 21225</i>						25a. REC'D BY REGISTRAR <i>JUL 13 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hospital		d. STREET ADDRESS Hunter Road	
3. NAME OF DECEASED (Type or print) First Middle Last BENTON EDWIN MARTIN		4. DATE OF DEATH Month Day Year 7 4 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23-88
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days Hours Min. 7 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Balto. Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Martin		14. MOTHER'S MAIDEN NAME Keziah Lawson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-01-3328	
17. INFORMANT Mr. Paul Martin		Address Hampstead, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/4 , 19 66 , to 7/4 , 19 66 , that (I) (we) last saw the deceased alive on 7/4 , 19 66 , and that death occurred at 3:45 M, from causes and on the date stated above.			
22a. SIGNATURE John S. Harshey		22b. DATE SIGNED 7/4/66	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS 8 Archer St. Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/6/66	
23c. NAME OF CEMETERY OR CREMATORY Salem EUB Cemetery		23d. LOCATION (City or Town) (County) (State) Balto. Co. Md.	
24. FUNERAL DIRECTOR Tipton-Eline		25a. REC'D BY REGISTRAR DATE JUL 7 1966	
ADDRESS Hampstead, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09750

CERTIFICATE OF DEATH

09748

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. LENGTH OF STAY IN 1b <i>8 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>23 Park Ave.</i>				d. STREET ADDRESS <i>23 Park Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>WOERNER</i> Middle <i>MC</i> Last <i>KINSEY</i>				4. DATE OF DEATH Month <i>July</i> Day <i>1</i> Year <i>1966</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 24 1890</i>	9. AGE (In years, last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Purchasing Agent Const. Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Fredrick, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Folger Mc Kinsey</i>				14. MOTHER'S MAIDEN NAME <i>Fannie H. Dungan</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>067-09-9513</i>		17. INFORMANT <i>Mrs Woerner Mc Kinsey</i> Address <i>same address</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5271</i> DUE TO <i>Pulmonary Emphysema</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Coronary Arteriosclerotic Heart Disease - Cerebral Vascular Insufficiency</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1966</i> , to <i>July 1, 1966</i> , that (I) (we) last saw the deceased alive on <i>July 1, 1966</i> , and that death occurred at <i>4:45 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>John S. Harshey</i>				22b. DATE SIGNED <i>7/1/66</i>		22c. PHYSICIAN'S NAME (Type) <i>JOHN S. HARSHEY, M.D.</i>	
22d. ADDRESS <i>8 Archer St. Westminster, Md.</i>				22e. REC'D BY REGISTRAR <i>J. Charles Judge</i>			
22f. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				22g. DATE <i>JUL 5 1966</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/5/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadow Brook Cemetery, Westminster, Md.</i>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <i>J. S. Myers, Jr., Westminster, Md.</i>							

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09751

09749

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 12 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 2607 Glenallen Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna Elizabeth McQuin		4. DATE OF DEATH July 9, 1966		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 2-6-91	
9. AGE (In years last birthday) 75 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 577-09-5358		17. INFORMANT Springfield Hospital Record, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9047 DUE TO POSSIBLE LEFT CEREBRAL THROMBOSIS (b) RT PARTIAL HEMIPLEGIA DUE TO FRACTURE NECK RT FEMUR (c) BRONCHIAL ASTHMA, DIABETES ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 days 1-2 weeks 6-29-66 ?		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on WARD WARFIELD DIVISION			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6/29 1966 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOSPITAL.	
20f. (City or town) SYKESVILLE		20g. (County) CARROLL		20h. (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE W. Glenn Spicher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 7-10-66	
EXAMINER'S NAME (Type) W. Glenn Spicher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/13/66		23c. NAME OF CEMETERY OR CREMATORY Parklawn	
23d. LOCATION (City, town or county) Rockville		23e. (State) Montgomery		24. FUNERAL DIRECTOR 1331 Rockville Tyson Wheeler Rockville, Maryland	
25a. REC'D BY REGISTRAR DATE JUL 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08751

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Woodbine</u> d. STREET ADDRESS <u>Woodbine Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>STUART H. Miller</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>August-1890</u> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>July 7</u> 19 <u>66</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN - Self Employed</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>?</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>578-12-6106</u> 17. INFORMANT <u>MR. Robert Killeth</u> Address <u>Sykesville, Md.</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Document Cerebral Hemorrhage</u> 449X DUE TO (b) <u>Arteriosclerotic hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cardio-vascular disease</u> DUE TO (c) <u>Cardio-vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Hemiplegia, Rt.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> Hour a.m. p.m.		20d. INJURY OCCURRED <u>19</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>Sykesville, Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 2</u> , 19 <u>65</u> , to <u>July 7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 5</u> , 19 <u>66</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Sani Okutman</u> 22c. PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>		22b. DATE SIGNED <u>7-9-66</u> 22d. ADDRESS <u>Sykesville, Md.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7-9-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Freedom Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Sykesville, Md.</u>		24. FUNERAL DIRECTOR <u>Harry W. Haight</u> <u>Sykesville, Md.</u> 24a. REC'D BY REGISTRAR <u>JUL 12 1966</u> 24b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

09751

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY in 1b <u>4yr. 4da.</u>		d. STREET ADDRESS <u>1909 E. 32nd. St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alan Penneman Moore</u>		4. DATE OF DEATH Month Day Year <u>July 23 19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 14, 1893</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce salesman</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Moore</u>		14. MOTHER'S MAIDEN NAME <u>Anna Scott Apy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 22days Med. disch.</u>		16. SOCIAL SECURITY NO. <u>216-05-1094</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4200 DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CBS, cerebral arteriosclerosis, with psychotic reaction. Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 17, 19 66</u> to <u>July 23, 19 66</u> that (I) (we) last saw the deceased alive on <u>7-23-66</u> 19 <u>66</u> , and that death occurred at <u>3:30A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>R. C. Lajonchere MD</u>		22b. DATE SIGNED <u>7-23-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rinaldo Lajonchere, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/25/66.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 25 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

00721

00720



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09754					09752				
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster</i> c. LENGTH OF STAY IN 1b <i>10 yrs.</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>267 Valen Road</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster</i> d. STREET ADDRESS <i>267 Valen Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>ALICE</i> Middle <i>MAE</i> Last <i>MYERS</i>			4. DATE OF DEATH Month <i>July</i> Day <i>3</i> Year <i>1966</i>		5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>Feb. 14 1902</i> 9. AGE (in years last birthday) <i>64</i> yrs. 10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife, worked in sewing factory</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Westminster Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Harry L. Graft</i>			14. MOTHER'S MAIDEN NAME <i>Mary Etta Little</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <i>216-01-6089</i>		17. INFORMANT <i>Mr Clayton E. Myers</i>		Address <i>same address</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Edema of lungs</i> 1437 DUE TO (b) <i>Right heart failure</i> DUE TO (c) <i>Adeno-carcinoma of metastases to lung, skin & subcutaneous gland</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>about</i> <i>10 hours</i> <i>operation</i> <i>9-65</i>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>none</i> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to on <i>7-3</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>2-3</i> , 19 <i>66</i> , and that death occurred at <i>9 P.</i> M., from the causes and on the date stated above.									
22a. SIGNATURE <i>C. H. Billingslea</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>7-4-66</i>				
22c. PHYSICIAN'S NAME (Type) <i>C. H. Billingslea</i>			22d. ADDRESS <i>Westminster, Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/6/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westminster Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Rural Westminster Md.</i>			
24. FUNERAL DIRECTOR <i>J. E. Myers, Jr.</i>			ADDRESS <i>Westminster Md</i>		25a. REC'D BY REGISTRAR <i>J. Charles Judge</i>		25b. REGISTRAR'S SIGNATURE		

00358

00358

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

B22

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
09755 CERTIFICATE OF DEATH 09753											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN TB <u>1 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Long View Nursing Home Inc.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SPARKS COCKEYSVILLE</u> d. STREET ADDRESS <u>Thornton Hill YORK RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Elva Myrth Parks</u>				4. DATE OF DEATH <u>7 29 1966</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/24/1891</u>		9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker Black & Decker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balbo Co. Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Nicholas Stevenson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Robinson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>Mrs. Helen Price - Sparks, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Myocardial Infarction</u> <u>4201</u> DUE TO <u>Interis Sclerotic C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>4201</u> (c) <u>4201</u>										INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				22b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 28 1966</u> to <u>July 29 1966</u> , that (I) (we) last saw the deceased alive on <u>July 28 1966</u> and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.											
22e. SIGNATURE <u>M. Porterfield</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Maurice Porterfield M.D.</u>				22d. ADDRESS <u>Main Street, Hampstead, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>JULY 31, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>JESSOP'S CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>COCKEYSVILLE, MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John K. Smith, Towson, Md.</u>				ADDRESS				25a. REC'D BY REGISTRAR <u>AUG 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00752

CERTIFICATE OF DEATH

00752

Given

and

Witness

Married

1911

Long V. Cunningham

Color

Height

Weight

F W

→

6/24/1911

Edward W. Cunningham

W 54

Richard Cunningham

James Cunningham

No

Two other given - fresh one

19

Maurice Peterfield M.D. Main Street, Hays, Kansas, May 1911

Witness given at the residence of the deceased

Witness given at the residence of the deceased

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09756									
09754									
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Finksburg				c. LENGTH OF STAY IN 1b 40 yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Finksburg			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle EDWARD Last PEELING					4. DATE OF DEATH Month July Day 23 Year 1966				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 18, 1896		9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) metal worker in airplane factory				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Carroll Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Albert Peeling					14. MOTHER'S MAIDEN NAME Estella V. Barnes				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16. SOCIAL SECURITY NO. 212-03-4007		17. INFORMANT Address Mrs. Martha C. Peeling - same				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of bladder & colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 1 yr 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7-2-65 , 19____, to 7-23-66 , 19____, that (I) and last saw the deceased alive on 7-22-66 , 19____, and that death occurred at 5:10 PM , from the causes and on the date stated above.									
22a. SIGNATURE D. D. Caples					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 7-25-66	
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.					22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF July 27, 1966		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery			23d. LOCATION (City, town or county) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md.					25a. REC'D BY REGISTRAR JUL 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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Nov. 12, 1950

Nov. 12, 1950

General G. L. ...

General G. L. ...

General G. L. ...

General G. L. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 20M 5-63

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) Martin Luther Hess Reaver						4. DATE OF DEATH Month July Day 25 Year 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1888		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 25 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own farm				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franklin Reaver						14. MOTHER'S MAIDEN NAME Ida Hess					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 215-34-2804		17. INFORMANT Mrs. Lina Reaver, R #1, Littlestown, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Generalized Arteriosclerosis (c) 7 yrs 10 yrs										INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia; Pulmonary Emphysema; Anemia 2°											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 2, 1959 to July 2, 1966 , that (I) (we) last saw the deceased alive on July 19, 1966 , and that death occurred at 4:25 PM from the causes and on the date stated above.											
22a. SIGNATURE E. Ambler Thompson M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/26/66			
22c. PHYSICIAN'S NAME (Type) E. Ambler Thompson, M.D.						22d. ADDRESS 49 Frederick Street, Taneytown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 28, 1966		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery				23d. LOCATION (City, town or county) (State) Harney Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John H. Skiles						ADDRESS C.O. Fuss & Son, Taneytown, Md.		25a. REC'D BY REGISTRAR UL 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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VR A15 (4)
20M 1/65

09758

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09756

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4 Cedarhurst Road				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Nd. f. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg d. STREET ADDRESS 4 Cedarhurst Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John		First John		Middle J.		Last Rhodes		4. DATE OF DEATH Month July Day 4 Year 19 66	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1903		9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles S. Rhodes				14. MOTHER'S MAIDEN NAME Eliza Miller					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-18-1318		17. INFORMANT Mrs. Grace A. Rhodes Address Finksburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 1143x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 2 hrs. years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 4, 1966 , to July 4, 1966 , that (I) (we) last saw the deceased alive on July 4, 1966 , and that death occurred at 4 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Martin E. Strobel								22b. DATE SIGNED 7-5-66	
22c. PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D.								22d. ADDRESS 48 Main St. Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/7/66		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION (City, town or county) (State) Finksburg, Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons ADDRESS Reisterstown, Md.						25a. REC'D BY REGISTRAR JUL 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

00728

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Franklin

Department of

John

John

John

Charles A. Rhodes

John

12-18-1918

Miss Miller

Miss A. Rhodes

Mark E. Rhodes

John

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John E. Rhodes

John

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09759

CERTIFICATE OF DEATH

09759

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring 21722	
c. LENGTH OF STAY IN 1b 1 y 5m 12d		d. STREET ADDRESS Route #1 unknown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Fillmore Robinson		4. DATE OF DEATH Month 7 Day 7 Year 1966	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-2-87
9. AGE (In years lost birthday) yrs. 78		IF UNDER 1 YEAR Months 7 Days 7 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd Jobs		10b. KIND OF BUSINESS OR INDUSTRY 66 --	
11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Robinson		14. MOTHER'S MAIDEN NAME Nancy Carbaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) none		16. SOCIAL SECURITY NO. 215-26-0812	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic cardiovascular disease DUE TO (c) years			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with cerebral arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --	
20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. -- 19 66	20d. INJURY OCCURRED While at work <input type="checkbox"/> While not at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --	20f. (City or town) (County) (State) --
21. I certify that he (this hospital) attended the deceased from 1-25 , 19 66 , to 7-7- , 19 66 , that we (we) last saw the deceased alive on 7/7 , 19 66 , and that death occurred at 7:30a M, from causes and on the date stated above.			
22a. SIGNATURE S. P. Wise III, M.D.		22b. DATE SIGNED 7-7-66	
22c. PHYSICIAN'S NAME (Type) S. P. Wise III, M.D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF July 9-66	23c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S CEMETERY	23d. LOCATION (City or Town) (County) (State) NEAR CLEARSPRING, WASH., Md.
24. FUNERAL DIRECTOR ALBERT L. LEAF WILLIAMSPORT, MD.		25a. RECEIVED BY REGISTRAR JUL 11 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

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Washington

Portland

Carton

21724

Green Spring

17 24 14

(Herald) Lykensville

Wagon

Route 11

Carton 17 24 14

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12-87

White

Halo

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17

10

Unit 10

Harry G. Gough

John Gough

Portland Hospital Records

None

Chronic

100

100

Chronic

Chronic

Chronic

1-25

1-25

Portland State Hospital

1-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN, IT SHOULD BE FILLED WITH
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09760		09758	
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>06-1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>HERMAN</u> Middle <u>Ruch</u> Last		4. DATE OF DEATH <u>July 22, 1966</u> Month <u>July</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1882</u>
9. AGE (In years, last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Fireman Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PAUL Ruch</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>217-01-8217</u>	
17. INFORMANT <u>Mrs. Mammie Ruch - Sykesville, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, arteriosclerosis, 451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>bronchial pneumonia - acute</u> DUE TO (c) <u>aneurysm</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Feb 66 to 7-22-66</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>7-22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-22-</u> 19 <u>66</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		22d. ADDRESS <u>Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-25-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LAKE VIEW PARK</u>		23d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Haight</u> ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 26 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
09761 CERTIFICATE OF DEATH 09759

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 11 mos. 27 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 30-4 d. STREET ADDRESS 6209 Gist Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MARY DAISY RYAN				4. DATE OF DEATH Month 7 Day 21 Year 1966							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-8-84		9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 21 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses' Aide				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (County & State, or foreign country) U.S.A.			
13. FATHER'S NAME Joseph Ryan				14. MOTHER'S MAIDEN NAME Margaret Berger							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 216-10-2003		17. INFORMANT Records, Springfield State Hospital				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) High fever, with poor rule 0534 DUE TO Sepsis. Focus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease and behavioral reaction. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 7-24-65 , 19____, to 7-21-66 , 19____, that (I) (we) last saw the deceased alive on 7-21-66 , 19____, and that death occurred at 7 P. M. from the causes and on the date stated above.											
22a. SIGNATURE Wm. R. Iqbal 22c. PHYSICIAN'S NAME (Type) Wm. R. IQBAL 22b. DATE SIGNED 10D SSH- 22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/25/66		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel -Rock Hall, Md.				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, Md. 25a. REC'D BY REGISTRAR JUL 25 1966 25b. REGISTRAR'S SIGNATURE Charles Judge											

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02761

Marshall

Marshall

Belmont

Belmont

4000 East Avenue

Springfield State Hospital

West Hill Road

82

5-11-81

White

Female

Marshall

Alma

Marshall Center

Joseph Ryan

Records, Springfield State Hospital

216-10-2003

no

Chronic brain syndrome caused by long term alcohol and drug abuse

1-11-82

1-11-82

W. A. Lloyd

Wesley Chapel - Rock Hill, S.C.

7/25/80

Marshall

Letter 0706-8728 Liberty St. Charleston, S.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
09762					CERTIFICATE OF DEATH					09761				
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville			c. LENGTH OF STAY IN lb 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 3501 Barclay Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First LAWA Middle EDNA Last Smith			4. DATE OF DEATH Month July Day 4 Year 1966											
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/7/84		9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months 4 Days 4 Hours 19 Min. 66				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Michael S. Butler					14. MOTHER'S MAIDEN NAME Henshaw, Lillie S.									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 216-09-3902 B		17. INFORMANT Address Springfield Hospital records, Sykesville									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 MI DUE TO (b) Heart failure DUE TO (c) Arteriosclerotic cardiovascular disease										INTERVAL BETWEEN ONSET AND DEATH 2 mo 2 mo 3 mo				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome Assoc = # I (c)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that the (this hospital) attended the deceased from 6/6/ , 19 66 , to 7/4/ , 19 66 , that it (we) last saw the deceased alive on July 4 , 19 66 , and that death occurred at 1:50 M, from causes and on the date stated above.														
22a. SIGNATURE S.P. Wise III					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 7/4/66						
22c. PHYSICIAN'S NAME (Type) Samuel P. Wise, III, M.D.					22d. ADDRESS Springfield State Hospital Sykesville, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/6/1966		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			23d. LOCATION (City or Town) (County) (State) Woodlawn, Md.						
24. FUNERAL DIRECTOR Wm. J. Tiekman & Sons					ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR DATE JUL 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

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09763

CERTIFICATE OF DEATH

09762

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 16 Yr. 1 Mo. 16 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown, Md.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS R.F.D.# 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Susan Springer		4. DATE OF DEATH Month Day Year 7- 17 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-89
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Washington Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred Holmes	
14. MOTHER'S MAIDEN NAME Margaret McAllister		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 220-54-6618	
16. SOCIAL SECURITY NO. 220-54-6618		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cardiac Failure DUE TO (c) 14 Days			INTERVAL BETWEEN ONSET AND DEATH Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-30 , 19 50 , to 7-17- , 19 66 , that (I) (we) last saw the deceased alive on 7-17- , 19 66 , and that death occurred at 4 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Frances Reid Nabors		22b. DATE SIGNED July 17, 1966	
22c. PHYSICIAN'S NAME (Type) Frances Reid Nabors		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) B	23b. DATE THEREOF 7- 19- 66	23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery	23d. LOCATION (City or Town) (County) (State) Samples Manor, Md.
24. FUNERAL DIRECTOR ADDRESS Best Funeral Home, 113 W. Main St., Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUL 20 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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09763

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b Hampstead R.D.1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. Gen. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead R.D.1 d. STREET ADDRESS Gill Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORMAN Middle P. Last STEPHAN		4. DATE OF DEATH Month 7 Day 25 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/15
9. AGE (In years last birthday) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Walter Stephan	
14. MOTHER'S MAIDEN NAME Mary Walsh		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 219-14-2184		17. INFORMANT Mrs. Margaret Stephan, Hampstead, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Several hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 25, 1966 to July 25, 1966 , that (I) (we) last saw the deceased alive on July 25, 1966 , and that death occurred at 9:35 M, from causes and on the date stated above.			
22a. SIGNATURE John S. Harshey		22b. DATE SIGNED 7/25/66	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, MD.		22d. ADDRESS 8 Anchor St. Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/28/66	23c. NAME OF CEMETERY OR CREMATORY Immanuel Cemetery	23d. LOCATION (City or Town) (County) (State) Manchester Md.
24. FUNERAL DIRECTOR Tipton-Eline		25a. REC'D BY REGISTRAR AUG 2 1966 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge	

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DEPARTMENT OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 1d Film G379 8/10/66 mh

CERTIFICATE OF DEATH

09765

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1. PLACE OF DEATH a. COUNTY <i>Carrroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carrroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>209 S. Main St.</i>		d. STREET ADDRESS <i>207 S Main Street</i>	
3. NAME OF DECEASED (Type or print) First <i>ROBERT</i> Middle <i>STEPHAN</i> Last <i>STEPHAN</i>		4. DATE OF DEATH Month <i>July</i> Day <i>29</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/24/95</i>
9. AGE (In years lost birthday) yrs. <i>71</i>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>County Rds. Employee</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Franklin Stephan</i>		14. MOTHER'S MAIDEN NAME <i>Ida Yingling</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>219-07-1941</i>	
17. INFORMANT <i>Mrs. Melvie Stephan</i>		Address <i>Manchester, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4201 Angina Pectoris</i> IMMEDIATE CAUSE (a) <i>Coronary Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Coronary Arteriosclerosis</i> (c) <i>Coronary Arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Cellulose spinal sub arachnoiditis 9 yrs.</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 28, 1966</i> , to <i>July 29, 1966</i> , that (I) (we) lost saw the deceased alive on <i>July 28, 1966</i> , and that death occurred at <i>5a</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>M.C. Porterfield</i>		22b. DATE SIGNED <i>July 29, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>M.C. Porterfield</i>		22d. ADDRESS <i>Hampstead, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>7/31/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Leister's Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Westminster Md.</i>
24. FUNERAL DIRECTOR <i>Tipton-Eline</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 2 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (New) Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 09766												09765								
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>1hr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Office of Dr. Okutman</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville 06-1</u> d. STREET ADDRESS <u>OAKLAND Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <u>Ethel</u> First <u>Trott</u> Middle <u>Trott</u> Last			4. DATE OF DEATH <u>July 22</u> 19 <u>66</u> Month <u>July</u> Year <u>1966</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>May 16, 1920</u>			9. AGE (In years last birthday) <u>46</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses Aide</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>			11. BIRTHPLACE (County & State, or foreign country) <u>N. C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>								
13. FATHER'S NAME <u>John CARVER</u>						14. MOTHER'S MAIDEN NAME <u>Nellie Hillman</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>218-32-3263</u>			17. INFORMANT <u>MR. MARVIN TROTT - Sykesville, Md.</u> Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cardiac asthma</u> DUE TO (c) <u>Arterio Sclerosis, Hypertension.</u>												INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>6 yrs</u> <u>6 yrs</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Phlebitis - Rt leg -</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)												
21. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>Jan 7, 1963</u> , to <u>July 22, 1966</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>July 22, 1966</u> , and that death occurred at <u>6:30</u> P.M., from the causes and on the date stated above.																				
22a. SIGNATURE <u>Sami Okutman</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>7.23.66</u>											
22c. PHYSICIAN'S NAME (Type) <u>Sami Okutman</u>						22d. ADDRESS <u>Sykesville, Md.</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-26-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW OAKLAND</u>				23d. LOCATION (City, town or county) (State) <u>Sykesville Md.</u>												
24. FUNERAL DIRECTOR <u>Harry W. Haight</u> ADDRESS <u>Sykesville, Md.</u>				25a. REC'D BY REGISTRAR <u>JUL 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
09767										
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b 4 mo. 13 d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 1500 Virginia Avenue					
3. NAME OF DECEASED (Type or print) Sarah			First Middle Last Levy Twigg		4. DATE OF DEATH July 1 1966		5. SEX Female			
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-10-1889		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harris Levy					14. MOTHER'S MAIDEN NAME Bessie Simon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Springfield Hospital, Sykesville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with circulatory disturbance other than cerebral arteriosclerosis, with psychotic reaction.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from February 18 1966, to July 1, 1966, that (X) (we) last saw the deceased alive on July 1, 1966, and that death occurred at 3:30 PM from the causes and on the date stated above.										
22a. SIGNATURE Naci Buyukunsal, M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Naci Buyukunsal, M.D.					22d. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF July 3, 1966		23c. NAME OF CEMETERY OR CREMATORY East View Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR John J. Hafer 230 Balto Ave. Baltimore Ave Cumberland Md.					25a. REC'D BY REGISTRAR DATE JUL 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleburg c. LENGTH OF STAY IN IB 1 yr. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brookfield Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle A. Last WAYNANT		4. DATE OF DEATH Month July Day 31 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1897
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 10 Days 2	IF UNDER 24 HRS. Hours 19 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Amaricus E. Waynant	
14. MOTHER'S MAIDEN NAME Marion J. Bender		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Vaughn Waynant Address Sabillasville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral atherosclerosis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Atherosclerosis cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/6/65 , 19 65 , to 7/31/66 , 19 66 ; that (I) (we) last saw the deceased alive on 7/31/66 , 19 66 , and that death occurred at 10:20 M, from the causes and on the date stated above.			
22a. SIGNATURE J.H. Caricofe M.D.		22b. DATE SIGNED 7/31/66	
22c. PHYSICIAN'S NAME (Type) J.H. Caricofe		22d. ADDRESS Union Bridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-3-66	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery	23d. LOCATION (City, town or county) (State) Thurmont Fred. Co. Md.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greager ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR AUG 3 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF MARRIAGE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, add in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
09763					09768					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <i>Carroll</i>					e. STATE <i>New York</i> b. COUNTY <i>King's</i> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
<i>Manchester</i>					<i>New York City</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					
<i>Long View Nursing Home Inc</i>					<i>210, W 70th Street</i>					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First <i>Lilly</i> Middle <i>Weigel</i> Last <i>Weigel</i>					Month <i>July</i> Day <i>29</i> Year <i>1966</i>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years, last birthday)		
<i>Female</i>		<i>White</i>		<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>Dec 29, 1871</i>		<i>94</i> yrs.		
								IF UNDER 1 YEAR Months Days		
								IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>House wife</i>							<i>Holyoke Mass.</i>		<i>U.S.A</i>	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
<i>Samuel Keller</i>					<i>Sarah Wolff</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT			
<i>No</i>					<i>098-12-8345</i>		<i>Institution Records, Manchester, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Carcinoma of Breast (left)</i>										
170X DUE TO										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										
<i>Arterio-sclerotic C-v. Disease</i>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>July 27, 1966</i> to <i>July 29, 1966</i> , that (I) (we) last saw the deceased alive on <i>July 29, 1966</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.										
22e. SIGNATURE <i>Maurice Porterfield</i>					22b. DATE SIGNED <i>7-30-66</i>					
22c. PHYSICIAN'S NAME (Type) <i>Maurice Porterfield M.D</i>					22d. ADDRESS <i>Main Street, Hampstead, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)		
<i>Burial</i>		<i>8/3/66</i>		<i>MacPelah Cemetery</i>		<i>Brooklyn</i>		<i>N.Y.</i>		
24 FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR					
<i>Tipton-Eline</i>					<i>Hampstead, Md.</i>					
					25b. REGISTRAR'S SIGNATURE					
					<i>Charles Judge</i>					
					DATE <i>AUG 2 1966</i>					

02763

Lilly

Katie Miller

Housewife

Samuel Keller

Ac

in the inc

Wingel

Dec 21 1871

Holgers Mrs

Zarah Wolff

027-12-207 Jackson Records Newark, NJ

New Air City

210 W 1st Street

July 22

pt

W 2 H

New York

Amoy

CLINTON CALL OF DEATH

02763

Manuel Portfield 113 Mon Street, Hempstead, N.Y.

Brooklyn

Manuel Portfield

02763

Simon-Mine

Manuel Portfield

Manuel Portfield

09770

CERTIFICATE OF DEATH

09769

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminister</u> c. LENGTH OF STAY IN lb <u>2 yrs.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminister</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>297 E. Main St.</u>		d. STREET ADDRESS <u>297 E. Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gladys</u> Middle <u>A.</u> Last <u>Whelan</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1902</u> 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Beassie Sammons</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-03-8604</u> 17. INFORMANT <u>Thomas M. Whelan</u> <u>297 E. Main St. - 21157</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Environmental Temperature</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/19</u> , 19 <u>66</u> , to <u>7/19</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>Never</u> 19 <u> </u> , and that death occurred at <u>2:40</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>William R O'Rourke</u> M.D.		22b. DATE SIGNED <u>7/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William R. O'Rourke, M. D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-22-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Pk.</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>
24. FUNERAL DIRECTOR <u>Wither F. D. - 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 20 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

00700

CERTIFICATE OF DEATH

00700

Name of Deceased		Date of Birth		Sex	
John Doe		1900-01-01		Male	
Place of Birth		Date of Death		Cause of Death	
New York City		1950-01-01		Heart Disease	
Occupation		Residence		Burial Place	
Teacher		123 Main St		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Issued by		Official Seal	
1950-01-01		John Doe		[Seal]	

CERTIFICATE OF DEATH

09771

09770

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN ly. 11m. 22d.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maudie Middle Belle Last White		4. DATE OF DEATH Month 7 Day 5 Year 19 66			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/87	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 7 Days 5 Hours 19 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Sargent		14. MOTHER'S MAIDEN NAME Luella Rogers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-10-1224		17. INFORMANT Address Springfield Hospital records, Sykesville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4341					INTERVAL BETWEEN ONSET AND DEATH days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome with cerebral arteriosclerosis with psychotic reaction.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that the (this hospital) attended the deceased from 7/13/ , 19 64 , to 7/5/ , 19 66 , that the (we) last saw the deceased alive on 7/5/ 19 66 , and that death occurred at 6:30 M, from causes and on the date stated above.					
22a. SIGNATURE Moises Sucholeiki		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/5/66	
22c. PHYSICIAN'S NAME (Type) Moises Sucholeiki, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-7-66	23c. NAME OF CEMETERY OR CREMATORY Savage Cem	23d. LOCATION (City or Town) Savage Howard Md (County) _____ (State) _____		
24. FUNERAL DIRECTOR Robert D. Donaldson		ADDRESS Lawrence H. H.		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge
		DATE JUL 7 1966			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

17520

05290

09772

CERTIFICATE OF DEATH

09771

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY in 1b <u>25 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RT. #4 06-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL Co. GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>CRANBERRY ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY CATHERINE</u> Middle <u>WIKE</u> Last <u>WIKE</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>21</u> Year <u>1966</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 27, 1913</u>	9. AGE (In years lost birthday) <u>53 yrs.</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE, WORKER IN CANNING FACTORY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL Co. MARYLAND</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM THOMAS CARR</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELLEN CARR</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>219-01-1765</u>		17. INFORMANT Address <u>505 E. MAINS ST. WESTMINSTER MD</u> <u>MRS FRANCIS E. ARBAUGH</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>several hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/21/66</u> , 19 <u>66</u> to <u>7/21/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/21 1966</u> , and that death occurred at <u>11:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John S. Harshey</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>				22d. ADDRESS <u>8 Anchor St. Westminster, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/25/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LEISTER'S CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>RURAL, WESTMINSTER MD</u>	
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr., Westminster, Md</u>				25a. REC'D BY REGISTRAR <u>JUL 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15700

STATE OF TEXAS

15700



TO THE STATE OF TEXAS
FROM THE STATE OF TEXAS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
09773 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09772

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hampstead, Md</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hampstead, Md</i>	
c. LENGTH OF STAY IN 1b <i>26 yrs.</i>		d. STREET ADDRESS <i>320 N. Main St</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>VIRGIL</i> Middle <i>R</i> Last <i>WILHELM</i>		4. DATE OF DEATH Month <i>July</i> Day <i>31</i> Year <i>1966</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/22/84</i>
9. AGE (In years (last birthday)) <i>81</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Peter Wilhelm</i>		14. MOTHER'S MAIDEN NAME <i>Maetka Hale</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-16-173</i>	
17. INFORMANT <i>Mrs. Virgil Wilhelm</i>		Address <i>Hampstead, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Myocardial Infarction</i> <i>4201</i> DUE TO (b) <i>Coronary Artery Sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			INTERVAL BETWEEN ONSET AND DEATH <i>7 hrs</i> <i>Intom</i>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Maurice C. Porter</i>		22. DATE SIGNED <i>July 31, 1966</i>	
EXAMINER'S NAME (Type) <i>Darcy</i>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/3/66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Grace Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Balto Co. Md</i>	
24. FUNERAL DIRECTOR <i>Tipton-ELine</i>		ADDRESS <i>Hampstead, Md</i>	
25a. REC'D BY REGISTRAR <i>gcharles judge</i>		25b. REGISTRAR'S SIGNATURE <i>gcharles judge</i>	
DATE <i>AUG 3 1966</i>			

02775

02775

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09774

09773

MEDICAL CERTIFICATION

10773

30374

General

General

General - Illinois

General - Illinois

General - Illinois

General - Illinois

General - Illinois

General - Illinois

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09775

CERTIFICATE OF DEATH

09774

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER, MARYLAND</u>	
c. LENGTH OF STAY IN 1b <u>4 WEEKS</u>		d. STREET ADDRESS <u>24 MANCHESTER AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL COUNTY GEN. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUTH MILDRED ZEPP</u>		4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 11, 1906</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL COUNTY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARVEY HARRIS</u>		14. MOTHER'S MAIDEN NAME <u>MAE TRIPE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-09-0703</u>	
17. INFORMANT <u>MR. HERSHELL ZEPP</u>		Address <u>24 MANCHESTER AVE WESTMINSTER, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF COLON WITH</u> <u>1538</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>WIDESPREAD METASTASES</u> DUE TO (c) <u>10 MO.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ARTERIO SCLEROTIC HEART DISEASE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/5</u> , 1966, to <u>7/4</u> , 1966, that (I) (we) last saw the deceased alive on <u>7/4</u> , 1966, and that death occurred at <u>7:15</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Vincent J. Fiocco</u> M.D.		22b. DATE SIGNED <u>7/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>VINCENT J. FIOCCO</u>		22d. ADDRESS <u>ANCHOR ST. WESTMINSTER</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JULY 7 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH</u>	23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER, CARROLL</u>
24. FUNERAL DIRECTOR <u>James G. Saffell</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
ADDRESS <u>WESTMINSTER, MD</u>		25b. REGISTRAR'S SIGNATURE <u>MD.</u>	

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05380

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09776

CERTIFICATE OF DEATH

09775

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (rural) Sykesville		c. LENGTH OF STAY IN lb 6y 3m 20d	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 207 W. 7th. Street	
3. NAME OF DECEASED (Type or print) First Grafton Middle Bernard Last Zimmerman		4. DATE OF DEATH Month 7 Day 5 Year 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-65-1895
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months 7 Days 5 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward J. George Zimmerman		14. MOTHER'S MAIDEN NAME Amanda Staley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infected gangrenous decubitus ulcers DUE TO (c) Bronchopneumonia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with diseases of unknown or uncertain cause, Huntington's Chorea, with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Minutes 455X Weeks 7-5 Months 19 66 Days 7-5	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State) --	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3-15 , 19 66 , to 7-5 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7-5 , 19 66 , and that death occurred at 4:30M , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 7-6-66	
22c. PHYSICIAN'S NAME (Type) A. Arengo, M.D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF July 9-1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR M.R. Etchison & Son		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		DATE JUL 11 1966	

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A. A. M. ...